DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To: Home Infusion Therapy Providers
Parenteral Nutrition Therapy Providers
Managed Care Plans

Memorandum No.: 04-29 MAA
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For Information Call:
1-800-562-6188

From: Douglas Porter, Assistant Secretary
Medical Assistance Administration

Subject: **Home Infusion Therapy/Parenteral Nutrition Program – Billing Instructions Changes**

Effective for dates of service on and after June 5, 2004, MAA is making some minor changes to the Home Infusion Therapy/Parenteral Nutrition Program Billing Instructions, dated October 2003. These changes do not affect current billing procedures. This memorandum explains the changes.

What has changed?

Effective June 5, 2004, MAA has updated the Home Infusion Therapy/Parenteral Nutrition Program Billing Instructions. The updates are minor and consist of rewording and rearranging information to improve the flow of the document so it is easier to read and follow. The changes are for clarity purposes only and do not change current billing procedures.

One notable change is that MAA more specifically defined the coverage criteria for Home Infusion Therapy/Parenteral Nutrition Program for clients who have a gastrointestinal impairment that is expected to last less than three months. Please see page C.3 for details on coverage for these clients.

Attached are replacement pages 1/2, 3/4, A.3/A.4, C.1/C.2, C.3/C.4 and E.1/E.2 for MAA's Home Infusion Therapy/Parenteral Nutrition Program Billing Instructions, dated October 2003. To obtain this memorandum or MAA's issuances electronically, go to MAA's website at http://maa.dshs.wa.gov (click on the Provider Publications/Fee Schedules link)

Definitions

This section defines terms and acronyms used throughout these billing instructions.

Authorization – MAA official approval for action taken for, or on behalf of, an eligible Medical Assistance client. This approval is only valid if the client is eligible on the date of service.

By Report (BR) – A method of reimbursement for covered items, procedures, and services for which the department has no set maximum allowable fees. MAA may require the provider to submit a written report to determine reimbursement. [WAC 388-500-0005]

Client – An individual who has been determined eligible to receive medical or health care services under any MAA program. [WAC 388-500-0005]

Code of Federal Regulations (CFR) – Rules adopted by the federal government. [WAC 388-500-0005]

Community Services Office (CSO) - An office of the department's Economic Services Administration (ESA) that administers social and health services at the community level. [WAC 388-500-0005]

Core Provider Agreement - The basic contract between MAA and an entity providing services to eligible clients. The Core Provider Agreement outlines and defines terms of participation in medical assistance programs. [WAC 388-500-0005]

Department - The state Department of Social and Health Services [DSHS]. [WAC 388-500-0005]

Disposable Supplies - Supplies that may be used once, or more than once, but cannot be used for an extended period of time. [WAC 388-500-0005]

Durable Medical Equipment (DME) – Equipment that:

(a) Can withstand repeated use;
(b) Is primarily and customarily used to serve a medical purpose;
(c) Generally is not useful to a person in the absence of illness or injury; and
(d) Is appropriate for use in the client's place of residence.

[WAC 388-500-0005]

Duration of Therapy - The estimated span of time that therapy will be needed for a medical problem. [WAC 388-553-200]

Emergency Medical Services – Medical services required by and provided to a patient experiencing an emergency medical condition. [WAC 388-500-0005]

Episode - A continuous period of treatment regardless of the number of therapies involved.

Explanation of Benefits (EOB) – A coded message on the medical assistance Remittance and Status Report that gives detailed information about the claim associated with that report. [WAC 388-500-0005]

Explanation of Medicare Benefits (EOMB) – A federal report generated for Medicare providers displaying transaction information regarding Medicare claims processing and payments.

Health Care Payment and Remittance Advice - The Health Care Payment and Remittance Advice is the standard X-12 transaction, number 835, implemented as part of the federal Health Insurance Portability and Accountability Act (HIPAA). The 835 is the HIPAA alternative to the Remittance and Status Report (RA). It is intended for provider use in reconciling claims.

Home Health Agency - An agency or organization certified under Medicare to provide comprehensive health care on a part-time or intermittent basis to a patient in the patient's place of residence. [WAC 388-551-2010]

Hyperalimentation – See "Parenteral Nutrition." [WAC 388-553-200]

Infusion Therapy – The provision of therapeutic agents or nutritional products to individuals by parenteral infusion for the purpose of improving or sustaining a client's health. [WAC 388-553-200]

Infusion Therapy Provider - An entity or individual who has been authorized by MAA to provide equipment and supplies for parenteral administration of therapeutic agents to medical assistance clients.

Intradialytic Parenteral Nutrition (IDPN) - Intravenous nutrition administered during hemodialysis. IDPN is a form of parenteral nutrition. [WAC 388-553-200]

Internal Control Number (ICN) - A 17-digit number that appears on your *Remittance and Status Report* by the client's name. Each claim is assigned an ICN when it is received by MAA. The number identifies that claim throughout the claim's history.

Limitation Extension – A process for requesting reimbursement for covered services whose proposed quantity, frequency, or intensity exceeds that which MAA routinely reimburses. Limitation extensions require prior authorization. [WAC 388-500-0005]

Managed Care - A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services. [WAC 388-538-050]

Maximum Allowable - The maximum dollar amount MAA will reimburse a provider for a specific service, supply, or piece of equipment. [WAC 388-500-0005]

Medicaid - The state and federally funded Title XIX program under which medical care is provided to persons eligible for the categorically needy program (CNP) or medically needy program (MNP). [WAC 388-500-0005]

Medical Assistance Administration (MAA) - The administration within DSHS authorized by the secretary to administer the acute care portion of Title XIX Medicaid, Title XXI state-children's health insurance program (S-CHIP), Title XVI, and the state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Medical Consultant - A physician employed by the department. [WAC 388-500-0005]

Medically Necessary - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-0005]

Medicare - The federal government health insurance program, for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare. [WAC 388-500-0005]

Nonreusable Supplies – Disposable supplies, which are used once and discarded. [WAC 388-500-0005]

Parenteral Infusion – The introduction of a substance by means other than the gastrointestinal tract, referring particularly to the introduction of substances by intravenous, subcutaneous, intramuscular or intramedullary means. [WAC 388-553-200]

Parenteral Nutrition - The provision of nutritional requirements intravenously. Also known as **Total Parenteral Nutrition (TPN) or Hyperalimentation**
[WAC 388-553-200]

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each MAA client consisting of:

- First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

Permanent Impairment – An impairment that is more than three months in duration.

Plan of Treatment or **Plan of Care** – The written plan of care for a patient which includes, but is not limited to, the physician's order for treatment and visits by the disciplines involved, the certification period, medications, and rationale indicating need for services. [WAC 388-500-0005]

Prior Authorization – A process by which clients or providers must request and receive MAA approval for certain medical services, equipment, drugs, and supplies, based on medical necessity, before the services are provided to clients, as a precondition for provider reimbursement. Expedited prior authorization and limitation extensions are forms of prior authorization.
[WAC 388-500-0005]

Prior Authorization Number – An identification number issued to providers who have a signed contract(s) with MAA.
[WAC 388-500-0005]

Provider - Any person or organization that has a signed contract or core provider agreement with DSHS to provide services to eligible clients. [WAC 388-500-0005]

Provider Number – An identification number issued to providers who have signed contract(s) with MAA.
[WAC 388-500-0005]

Purchase Only (PO) - A type of purchase used only when either the cost of the item makes purchasing it more cost effective than renting it, or it is a personal item, such as a ventilator mask, appropriate only for a single user.

Remittance And Status Report (RA) - A report produced by MMIS, MAA's claims processing system, that provides detailed information concerning submitted claims and other financial transactions. See also *Health Care Payment and Remittance Advice.* [WAC 388-500-0005]

Rental - A monthly or daily rental fee paid for equipment.

Revised Code of Washington (RCW) - Washington state laws.

Skilled Nursing Facility (SNF) - An institution or part of an institution that is primarily engaged in providing:

- Skilled nursing care and related services for residents who require medical or nursing care;
- Rehabilitation services for injured, disabled or sick clients;
- Health-related care and services to individuals who, because of their mental or physical conditions, require care which can only be provided through institutional facilities

and which is not primarily for the care and treatment of mental diseases. (See Section 1919(a) of the Federal Social Security Act for specific requirements.)

Third Party - Any entity that is, or may be, liable to pay all or part of the medical cost of care of a federal Medicaid or state medical program client. [WAC 388-500-0005]

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.
[WAC 388-500-0005]

Total Parenteral Nutrition (TPN) – See "Parenteral Nutrition."
[WAC 388-553-200]

Usual & Customary Fee – The fee that the provider typically charges the general public for the product or service.
[WAC 388-500-0005]

Washington Administrative Code (WAC) - Codified rules of the State of Washington.

In order to bill for home infusion therapy/parenteral nutrition, MAA must first assign you an infusion therapy provider number. See the *Important Contacts* section for information on applying for an Infusion Therapy provider number.

Federally-Qualified Health Centers (FQHCs), Physicians, and Physician Clinics may provide home infusion therapy/parenteral nutrition services in a physician's office or physician clinic, unless the client resides in a nursing facility. Use the appropriate procedure codes from MAA's Physicians-Related Services Billing Instructions when billing for services.

Nursing Facilities: Some services and supplies necessary for the administration of infusion are included in the facility's per diem rate for each client. See the Home Infusion Therapy/Parenteral Nutrition Fee Schedule (Section E) to identify procedure codes that are included in the nursing facility per diem rate. A client's infusion pump, parenteral nutrition pump, insulin pump, solutions, and/or insulin infusion supplies are not included in the nursing facility per diem rate and are paid separately. [Refer to WAC 388-553-500(6)]

Outpatient Hospital Providers may provide infusion therapy/parenteral nutrition and bill using revenue codes. See MAA's Outpatient Hospital Billing Instructions.

Clients in a State-Owned Facility: Home infusion therapy/parenteral nutrition for MAA clients in state-owned facilities [state school, developmental disabilities (DD) facilities, mental health facilities, Western State Hospital and Eastern State Hospital] are purchased by the facility through a contract with manufacturers. MAA does not pay separately for home infusion supplies and equipment or parenteral nutrition solutions for these clients. [Refer to WAC 388-553-500(5)]

Clients who have Elected MAA's Hospice Benefit: MAA pays for home infusion/ parenteral nutrition separate from the hospice per diem rate only when both of the following apply:

- The client has a pre-existing diagnosis that requires parenteral support; and
- That pre-existing diagnosis is unrelated to the diagnosis that qualifies the client for hospice.

When billing using a hardcopy HCFA-1500 claim form, you must enter a "K" indicator in field 19 to identify that the infusion therapy services were unrelated to the terminal diagnosis. When billing electronically, you must enter a "K" indicator in the "comments" section. [Refer to WAC 388-553-500(5)]

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Coverage

Home Infusion Therapy

All infusion therapy must be medically necessary. The medical necessity for the infusion must be evident in the diagnosis code on the claim. If the diagnosis code does not indicate the medical need for the infusion, MAA may recoup the payment.

When does MAA cover infusion therapy in the home?

[Refer to WAC 388-553-300(3)(4)]

MAA will cover infusion therapy in the home when the client meets the following criteria. The client must:

(a) Have a written physician order for all solutions and medications to be administered;
(b) Be able to manage their infusion in one of the following ways:
  (i) Independently;
  (ii) With a volunteer caregiver who can manage the infusion; or
  (iii) By choosing to self-direct the infusion with a paid caregiver (see WAC 388-71-0580).
(c) Be clinically stable and have a condition that does not warrant hospitalization;
(d) Agree to comply with the protocol established by the infusion therapy provider for home infusions. If the client is not able to comply, the client's caregiver may comply;
(e) Consent, if necessary, to receive solutions and medications administered in the home through intravenous, enteral, epidural, subcutaneous, or intrathecal routes. If the client is not able to consent, the client's legal representative may consent; and
(f) Reside in a residence that has adequate accommodations for administering infusion therapy including:
  (i) Running water;
  (ii) Electricity;
  (iii) Telephone access; and
  (iv) Receptacles for proper storage and disposal of drugs and drug products.

MAA evaluates a request for home infusion therapy supplies and equipment or parenteral nutrition solutions that are not covered or are in excess of the home infusion therapy/parenteral nutrition program's limitations or restrictions, according to WAC 388-501-0165. See page D.2. [WAC 388-553-500]

Parenteral Nutrition

All parenteral nutrition must be medically necessary. The medical necessity for the product being supplied must be evident in the diagnosis code on the claim. If the diagnosis code does not indicate the medical need for parenteral nutrition, MAA may recoup the payment.

When is Parenteral Nutrition covered?

[Refer to WAC 388-553-300(5)]

To receive parenteral nutrition, a client must meet the conditions under Home Infusion Therapy (see page C.1) as follows:

(a) Have hyperemesis gravidarum or an impairment involving the gastrointestinal tract that lasts 3 months or longer, where either of these conditions prevents oral or enteral intake to meet the client's nutritional needs;
(b) Be unresponsive to medical interventions other than parenteral nutrition; and
(c) Be unable to maintain weight or strength.

When is Parenteral Nutrition NOT covered?

[Refer to WAC 388-553-300(6)]

MAA does not cover parenteral nutrition program services for a client who has a functioning gastrointestinal tract when the need for parenteral nutrition is only due to:

(a) A swallowing disorder;
(b) A gastrointestinal defect that is not permanent unless the client meets the criteria below;
(c) A psychological disorder (such as depression) that impairs food intake;
(d) A cognitive disorder (such as dementia) that impairs food intake;
(e) A physical disorder (such as cardiac or respiratory disease) that impairs food intake;
(f) A side effect of medication; or
(g) Renal failure or dialysis, or both.

When does MAA cover parenteral nutrition for a client who has a condition expected to last less than three months?

[Refer to WAC 388-553-300(7)]

MAA covers parenteral nutrition for a client whose gastrointestinal impairment is expected to last less than three months when:

(a) The criteria on page C.1 are met;
(b) The client has a written physician order that documents the client is unable to receive oral or tube feedings; and
(c) It is medically necessary for the gastrointestinal tract to be totally nonfunctional for a period of time.

When does MAA cover Intradialytic Parenteral Nutrition (IDPN) solutions?

[Refer to WAC 388-553-300(8)]

MAA covers intradialytic parenteral nutrition (IDPN) solutions when:

(a) The parenteral nutrition is not solely supplemental to deficiencies caused by dialysis; and
(b) The client meets the criteria on page C.1 (client eligibility) and items a.-c. on page C.2 under "**When is Parenteral Nutrition Covered?"**

What documentation is required to be in the client's medical record and available to MAA upon request when providing parenteral nutrition to Medical Assistance clients?

See page F.6 – Specific to Home Infusion Therapy/Parenteral Nutrition Program.

MAA evaluates a request for home infusion therapy supplies and equipment or parenteral nutrition solutions that are not covered or are in excess of the home infusion therapy/parenteral nutrition program's limitations or restrictions, according to WAC 388-501-0165. See page D.2. [WAC 388-553-500]

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Fee Schedule

Equipment/Supply Limitations

[Refer to WAC 388-553-500(1)(2)(3)(4)(5)(6)]

The home infusion therapy/parenteral nutrition program covers the following equipment and supplies for eligible clients, subject to the limitations and restrictions listed below:

- Home infusion supplies, limited to one month's supply per client, per calendar month.
- Parenteral nutrition (solutions), limited to one month's supply per client, per calendar month;
- One type of infusion pump, one type of parenteral pump, and/or one type of insulin pump per client, per calendar month and as follows:

  - ✓ All rent-to-purchase infusion parenteral and/or insulin pumps must be new equipment at the beginning of the rental period;
  - ✓ MAA covers the rental payment for each type of infusion, parenteral, or insulin pump for up to 12 months. (MAA considers a pump purchased after 12 months of rental payment.);
  - ✓ MAA covers only one purchased infusion or parenteral pump, per client in a five-year period;
  - ✓ MAA covers only one purchased insulin pump, per client in a four-year period.

Covered supplies and equipment that are within the described limitations listed above do not require prior authorization for payment. Requests for supplies and/or equipment that exceed the limitations or restrictions listed in this section require prior authorization and are evaluated on an individual basis.

The following are considered included in MAA's payment for equipment rentals or purchases:

- ✓ Instructions to a client or a caregiver, or both, on the safe and proper use of equipment provided;
- ✓ Full service warranty;
- ✓ Delivery and pick-up; and
- ✓ Set-up, fitting, and adjustments.

The following pages show the fee schedule for MAA's Home Infusion Therapy/ Parenteral Nutrition program.

Procedure Code	Description	NH Per Diem?	Maximum Allowable

Infusion Therapy Equipment and Supplies

• **Reimbursement is limited to a one-month's supply.**			
A4220	**Refill kit for implantable infusion pump.** Limited to 1 kit, per client, per month.	Y	$25.00
A4221	**Supplies for maintenance of drug infusion catheter, per week**; (List drug(s) separately) (includes dressings for the catheter site and flush solutions not directly related to drug infusion). The catheter site may be a peripheral intravenous line, a peripherally inserted central catheter (PICC), a centrally inserted intravenous line with either an external or subcutaneous port, or an epidural catheter. Procedure code A4221 also includes all cannulas, needles, dressings, and infusion supplies (excluding the insulin reservoir) related to continuous subcutaneous insulin infusion via external insulin infusion pump (E0784). **1 unit = 1 week**	Y	22.15
A4222	**Supplies for external drug infusion pump, per cassette or bag** (List drug(s) separately). Procedure code A4222 includes the cassette or bag, diluting solutions, tubing, and other administration supplies, port cap changes, compounding charges and preparation charges.	Y	43.95

Antiseptics & Germicides

• **Reimbursement is limited to a one-month's supply.**			
A4244	Alcohol or peroxide, per pint. 1 pint per client, per 6 months	Y	$0.76
A4245	Alcohol wipes, per box 1 box per client, per month	Y	2.30
A4246	Betadine or Phisohex solution, per pint. 1 pint per client, per month	Y	3.03
A4247	Betadine or iodine swabs/wipes, per box of 100. 1 box per client, per month	Y	4.72
E1399	Disinfectant spray, 12 oz. 1 per client, per 6 months **Must bill using EPA code 870000869. See page D.2 for expedited prior authorization instructions.**	Y	4.30